Chapter 14

UN Peacekeepers and Civilian Field Personnel

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This chapter is unlike any other in this volume. Instead of addressing traumatic stress among people who require UN assistance because of social circumstances or humanitarian emergencies, we focus on the needs of UN personnel charged with providing such assistance. Although this is a massive topic, we attempt to succinctly review the nature of the stressors experienced by these individuals, their potential psychological impact, the consequences of institutional failure to address such adverse exposure and responses, what can be learned from the relevant literature, and what intervention models to consider. We provide illustrative case examples, identify important gaps in our current knowledge, and generate a series of recommendations.

Due to space constraints, we discuss UN peacekeepers and civilian field personnel in the same chapter. By civilian field personnel, we refer to staff both of parent UN organizations (e.g., UNHCR, WHO, UNICEF, etc.) as well as to staff of non-governmental organizations (NGOs). This category includes humanitarian personnel responding to acute refugee or disaster emergencies, human rights officials gathering evidence on crimes against humanity, or social service providers dealing with human misery (e.g., social deprivation; social injustice; aggression and injustice against women; child abuse; religious or ethnic repression; or discrimination against disabled individuals or the elderly). Despite some overlap, there are important distinctions to be drawn between these two large heterogeneous

sets of UN operatives. There have been approximately 35 deployments of peacekeeping forces since 1948. There is an emerging scientific literature on the psychological impact of such assignments. Military officials from many nations have made these concerns a high priority, and there are a number of interventions that have begun to be tested.

The picture is quite different for civilian field staff. Indeed, recognition has been slow that UN responsibilities may have adverse psychological consequences which may deleteriously affect both functional performance and long-term adjustment. There is a sparse scientific literature, little official national or international attention to this problem, and virtually no institutional resolve to address these consequences systematically. With the exception of one recent report concerning NGO humanitarian personnel (Eriksson, Van De Kemp, Gorsuch, Hoke & Foy, 2001), the literature cited here is extrapolated from pertinent research with professionals who work with other trauma survivors such as emergency medical personnel, disaster responders, police, firefighters, or mental health professionals.

NATURE AND SCOPE OF THE PROBLEM

Stressors and Potentially Traumatizing Events

Table 14.1 lists the kinds of stressors that may be encountered by UN personnel in the course of their duties. The nature of the assignment will obviously affect the risk of exposure to certain stressors. For example, UN peacekeepers are more likely to struggle with ambiguous rules of engagement, frustration from the need to maintain neutrality (especially in the face of threats, harassment, and taunting), and hostility of the host country. Civilian field personnel may be more likely to experience hopelessness and guilt due to their inability to change the external situation (e.g., starvation), inability to meet personal expectations for success, or a sense of powerlessness vs. denial in the face of unremitting demands by the massive number of people requesting assistance. Both groups may experience personal vulnerability (e.g., attacks, kidnappings, or hostage situations) as well as exposure to the acute consequences of war, disasters, human carnage, or deprivation; they are likely to witness the ongoing suffering of the populations they have been tasked to assist or protect, the ongoing violence or abuse, and boredom, inactivity, and uncertainty in the midst of danger. A final set of stressors, the most preventable, includes shock from the lack of pre-deployment preparation, and distress due to sudden separation from the safety and familiarity of the home environment. Let us provide a few illustrative examples of these stressors.

Table 14.1. Stressors and Potentially Traumatizing Events Experienced by UN Personnel

Personal Vulnerability, Attacks, Kidnapping, Kept as Hostage, Sexual Assault
Encountering the Acute Consequences of War, Disasters, Human Carnage, Starvation, Deprivation
Exposure to Emotional Suffering of Populations Assisting
Witnessing Ongoing Trauma, Violence, or Abuse
Ambiguous Rules of Engagement for Peacekeepers
Frustration from the Need to Maintain Neutrality in the Face of Threats, Harassment & Taunting (Peacekeepers)
Hopelessness/Guilt Due to Inability to Change External Situation (Civilian Field Personnel)
Inability to Meet Personal Expectations for Success (Civilian Field Personnel)
Hostility of Host Country/Environment
Sudden Detachment/Separation from Familiar/Safe Environment
Shock due to Lack of Pre-deployment Preparation
Powerlessness vs. Denial in the Face of Unremitting Demands
Boredom/Inactivity/Uncertainty in the Midst of Danger

Swedish soldiers deployed to peacekeeping operations in Congo, Lebanon, Cyprus, and Bosnia reported cognitive and emotional stressors. *Cognitive stressors* included: overstimulation alternating with periods of deprivation; too much information at certain times in contrast to too little information at other times; uncertainty; unpredictability; hard choices vs. no choices; and ambiguous rules of engagement. *Emotional stressors* included: threats of death or injury; loss of close colleagues; resentment, anger, and rage; boredom; and moral conflicts (Lundin & Otto, 1992).

Individual American peacekeepers deployed to Somalia reported the following specific stressful incidents: being shot at, driving a truck in a convoy behind a vehicle blown up by a land mine, experiencing intense fear while riding in a convoy under attack, and witnessing severe starvation, dying children and the bloody aftermath of an attack in which he or she could have been killed (Litz, 1996).

NGO humanitarian personnel reported a number of stressors in which they were personally exposed to life threatening situations that were experienced as very distressing. The most frequent events of this sort included: being threatened with serious physical harm; being shot at; being chased by a group or individual; sustaining damage to home or office by bombing or shelling; and witnessing death, injury, or destruction of property (Eriksson et al., 2001).

Humanitarian aid workers in Goma, Zaire in 1994 had to function in a situation in which they were exposed to people dying by the thousands due to dehydration, children sitting for hours uncomprehendingly beside their mothers who had just died,

and the daily visual, olfactory, and emotional reminders of such enormous suffering because disposal of dead bodies was such a massive logistical challenge that the same dead bodies often remained in the same location for days or weeks (Smith, Agger, Danieli, & Weisæth., 1996). "The conditions in the camps were unnerving to relief workers not only because of the crowding, the smells, the filth and the bodies, but because no one was able to fill a small percentage of the need" (Smith et al., 1996, p. 401).

During the siege of Sarajevo in 1992, humanitarian workers were exposed to threats to their own lives or well-being, such as random violence from sniper fire, food shortages, uncertainty whether the city would or would not be occupied, and total disruption of civil life. Paradoxically, these incessant dangers promoted a sense of intense bonding, compassion, and warmth among humanitarian workers who shared the same risks as the people they had come to help (Smith et al., 1996).

Distinctiveness of Stressful Experiences of UN Professionals

The stress and trauma literature has focused, for the most part, on the emotional impact of overwhelming stressors on exposed individuals. The intensity, persistence, uncontrollability, and unpredictability of the events described above may sometimes have profound emotional consequences. UN personnel deployed to a war zone, disaster site, refugee camp, scene of crimes against humanity, or region marked by injustice or deprivation are exposed to severe and overwhelming stressors even though they may not have suffered the personal loss of loved ones, home, community, or way of life experienced by the people they have come to assist.

In addition, the responsibilities of civilian field workers and peacekeepers, by their very nature, make this work extremely difficult. Listening to people talk about suffering, child abuse, or lack of basic needs, or witnessing continued violence, injustice, or state terrorism may also be very stressful for field personnel because they cannot intervene to improve the situation (Litz, Orsillo, Friedman, Ehlich, & Batres, 1997). In short, UN and NGO personnel face a unique set of potential psychological problems in addition to those shared with the people they are assisting.

It is important to emphasize that since this book is about the impact of traumatic stressors that is our major focus. To put this chapter into its proper context, however, it should be understood that in practice, there are other common but significant stressors with which peacekeepers must contend. Indeed, according to Dr. Christen Halle, Chief of the UN Department of Peacekeeping Operations (DPKO) Medical Support Services, these non-traumatic stressors may constitute the greatest concern for the majority of peacekeepers. They include understimulation, boredom, separation from loved ones (already mentioned) as well as the guilt and frustration of being unable to support the partner at home when s/he must contend with

Table 14.2. Potential Consequences of Institutional Failure to Address Stressful Aspects of UN Peacekeeping/Civilian Field Assignments

To UN/NGO Personnel
Emotional Distress During Deployment
Alcoholism and Drug Abuse/Dependence
Insensitivity to the Needs of Others: Numbing, Dissociation, Hostility, Cynicism
Burnout
Persistent Psychological Distress
Posttraumatic Stress Disorder
Persistent Functional Impairment
To UN and NGO Missions
Performance Deficits and Inefficiencies
Attrition of Trained Personnel
Increased Costs
Success of the Mission in Jeopardy

difficult problems, and the limited chance to achieve what could have been achieved during the deployment because there was little or no opportunity to do so (C. Halle, personal communication, 2001).

Consequences of Institutional Failure to Address this Problem

As noted earlier, while the military establishments of many UN member nations have recognized the deleterious impact of extreme stressors experienced during peacekeeping, civilian institutions and agencies have been much slower to acknowledge and address these problems. Thus, some UN or NGO personnel may become so emotionally distressed that they develop acute and/or chronic psychological symptoms that may impair their functional capacity in the field or at home. The institutional costs of this problem include decreased productivity, low morale, attrition of trained personnel, and higher monetary expenses, all of which jeopardize the successful completion of the mission as well as the reputation of the UN or NGO as an effective organization that can achieve its stated aims.

Table 14.2 lists adverse consequences to the individual and to UN and NGO missions when the emotional impact of mission-related stressors is not addressed. Although there is clearly a relationship between individual and institutional problems, we believe it useful to address them separately, because separate preventive strategies must be considered at both the individual and institutional level.

Consequences to the Individual

The assignments of peacekeepers and civilian field personnel are challenging and difficult. Bearing witness to the suffering of fellow human

beings is a part of the job. Responding emotionally to such sights, sounds, and smells is a normal human reaction. Indeed the sensitivity and compassion generated by such feelings can sometimes promote a sense of purpose and dedication that not only enhances the determination of UN or NGO personnel to carry out their assigned duties, but may also elevate the quality of their performance in the field.

On the other hand, strong emotional reactions to mission-related stressors can also have adverse psychological consequences. Such reactions may be acute emotional responses that occur only in the field of operations. Other responses may persist long after repatriation and, in some cases, may result in persistent psychological or functional problems.

Peacekeepers and civilian field workers experience a variety of acute reactions that may be divided roughly into *intrusive* and *avoidance* reactions (Smith et al., 1996). These reactions develop from the enormity of mission-related demands to ameliorate the suffering of war-zone survivors, refugees, disaster victims, and others who require assistance. Multiplying the suffering of one severely traumatized person by the comparable distress of hundreds or thousands of similarly affected individuals may produce a spectrum of intrusive reactions including feelings of helplessness, horror, frustration, anger, guilt, and enmeshment.

Intrusive Reactions. Peacekeepers have reported fear, helplessness, horror, a sense of vulnerability, frustration, anger, guilt, conflict over the demand to maintain neutrality, fear of losing control over their aggressive impulses, and moral/spiritual confusion (Egge, Mortensen, & Weisæth, 1996; Litz, 1996; Lundin & Otto, 1992; Orsillo, Roemer, Litz, Ehlich, & Friedman, 1998; Weisæth, Mehlum, & Mortensen, 1996).

Another set of intrusive reactions is related to a loss of personal boundaries (enmeshment) between UN or NGO personnel and the local population. Enmeshment is an insidious process in which relief workers over-identify with the victims of humanitarian crises, social deprivation, injustice, or interpersonal abuse, and lose both their objectivity and their capacity to intervene effectively (Smith et al., 1996).

In the most extreme manifestation of intrusive reactions, UN or NGO personnel will themselves begin to have mental images, nightmares, or other mental representations of traumatic events experienced—not by themselves, but by the people whom they have been sent to assist. This phenomenon has been called *vicarious traumatization, secondary traumatization,* or *compassion fatigue* (Figley, 1995; McCann & Pearlman, 1990). A comprehensive guide to the growing number of publications on this psychological process among helping professionals can be found elsewhere (Stamm, 1997). It should also be noted that very little of this literature has

focused on the unique problems of peacekeepers or civilian field personnel. Rather it is based on observations of police, firefighters, emergency medical personnel, disaster workers, or mental health practitioners who have worked in the security of a stable or peacetime environment. Yet, UN and NGO personnel must cope not only with the suffering of others, but also in some cases carrying out their responsibilities in an environment where their own personal safety is at risk.

Avoidance Reactions. It can be very difficult to maintain one's psychological equilibrium when faced with the intense personal and vicarious responses mentioned earlier. One way to minimize their impact is through a variety of behavioral or psychological strategies. At a conscious or behavioral level, personnel may avoid thoughts, feelings, people, or places that will evoke such feelings. In practice, such a strategy in its extreme results in the avoidance of the very people and situations they have been sent to assist (Danieli, 1984). The less conscious psychological strategy for minimizing intrusive emotions is called *psychic numbing*. This mechanism automatically suppresses intense emotional feelings. While this provides some degree of relief, a high price must be paid for numbing. Numbed personnel are incapable of empathy and other emotional acknowledgments of the suffering of others. In short, the personal protective strategies of behavioral avoidance or psychic numbing may seriously impair humanitarian workers from performing as they can and must. It makes them insensitive to others and affects their judgment, since they are liable to misjudge situations by minimizing their danger, urgency, or severity.

A related avoidant strategy is *dissociation* (Smith et al., 1996), which involves an altered perception of one's environment or oneself. During dissociation people feel detached from the world and themselves. Such a mechanism can markedly impair one's ability to recognize dangerous situations or to elicit normal emotional responses. Dissociation impairs both judgment and performance.

Fear, helplessness, and horror may also be transformed into hostility and cynicism (Smith et al., 1996). Such emotional redirection can be protective, can permit personnel to carry out their assignments, and can evolve into a lifelong reaction pattern that will prove extremely maladaptive after completion of the assignment, repatriation, and return to family.

Finally, another common avoidant strategy is misuse of alcohol or other drugs that will blunt the impact of intolerable mission-related intrusive emotional reactions.

Burnout is a problem that may afflict previously competent individuals who have lost either their motivation or capacity to perform as before. We distinguish it from the performance deficits discussed previously that

are due to mission-related traumatic stressors, because burnout is well-recognized as a problem that may occur in the safest work setting. It is related to generic work-related problems such as poor management, excessive demands, and/or inadequate rewards. Burnout affects individual performance and morale as well as the collective productivity and efficiency of the mission in general.

After recruitment and a brief orientation, Dr. Waters (a fictitious composite) had been sent to head a medical support unit in a refugee-camp situation. In the midst of insecurity, refugee need, and much suffering, the few humanitarian workers lived in a secured compound, a small haven that provided much-needed peace. However, away from friends, family and familiar social life, there was much boredom and many attempts to alleviate it. Besides the boredom, the suffering of so many in the refugee camp, the regular outbreaks of cholera, fighting, and killings that went on among the refugee factions, and limited communication with the outer world soon began to affect the workers.

At first, Dr. Waters was very optimistic, and he immersed himself in his work as supervisor of both expatriate and local medical staff. Although difficult, the work was an invigorating challenge. However, soon he started facing the realities around him. He was bone-tired many days, disturbed by the massive suffering all around him, and feeling increasingly helpless because his contribution did not seem to make much difference, since people continued to die from cholera faster than they could be buried. Several of his staff also contracted the illness. There was no hope of obtaining more fresh water for the camps. Refugees were arriving in such numbers as to overrun litter disposal, garbage collection, and construction of latrines. Then the rains came, and the children and the elderly developed pneumonia. Dr. Waters felt more fatigue and despair. To cope, he started drinking alcohol and smoking more than usual. This began affecting his practice, because he would wake up with a debilitating hangover, report late to work, and keep his team waiting. Although he was supposed to visit the clinics in the field, he would not leave the compound anymore, delegating his fieldwork while making excuses that he had enough to do in the office. He became suspicious of his coworkers, believing that the other expatriates were planning his undoing. This affected his sleep. He began taking medication, and his alcohol intake increased. It was then that his two senior colleagues decided to intervene. They talked to him in confidence, indicating their concern for his emotional and physical well-being. They suggested that he take a break to seek help. However, he insinuated that they were envious and blamed them for all the things that were going wrong around him. That night, in a rage, he wrote his letter of resignation, faxed it to his unit head in another country, and flew home the following morning.

Persistent Psychological Distress. Although intrusive and avoidant responses may impair psychological well-being and functional performance in the theater of operation, such reactions are especially deleterious when they persist after repatriation. Perhaps the best current data on this question comes from follow-up studies of Norwegian UNIFIL soldiers

(deployed to southern Lebanon) who were repatriated before the completion of their tour of duty (Weisæth et al., 1996). Repatriation was due to illness, injury, disciplinary reasons, and social or family problems. First, it is important to emphasize that 97% of the 15,931 Norwegian troops completed their UNIFIL assignment as planned, and regarded it as an extremely valuable and enlightening experience that had enhanced both their self-reliance and their capacity to cope with stress.

Among the 530 repatriated soldiers, however, comparative outcomes were decidedly negative, with higher rates of depression, alcoholism, suicides, death by accident, and psychosocial problems (Egge et al., 1996; Weisæth et al., 1996). Similar problems were observed in a follow-up study of Dutch UNIFIL veterans, 5% of whom reported excessive psychosocial problems, years after their return from south Lebanon (Knoester, 1989). Finally, a longitudinal study of 514 Swedish peacekeepers who served in Bosnia found 10% who reported psychological problems one year after deployment (Michel, Lundin, & Larsson, submitted for publication).

Unfortunately, there are very few long-range studies of UN peacekeepers following deployment. We, therefore, rely on long-term follow-up studies on military veterans from World War II, the Korean War, and the Vietnam War to provide estimates of psychological problems. These studies have shown that psychological and psychiatric symptoms are not only persistent but are usually associated with alcoholism, functional impairment, and poor psychosocial adjustment (Kulka et al., 1990).

Posttraumatic stress disorder [PTSD] was first described in the DSM-III in 1980 as a constellation of symptoms that develop when individuals are exposed to an extreme (emotional) stressor (APA, 1980). In its original formulation, exposure to the personal vulnerability, deprivation, human suffering, and witnessing of ongoing trauma associated with many peacekeeping or humanitarian deployments, would have easily qualified as a "traumatic" experience. As reformulated in the DSM-IV in 1994 (APA, 1994), such events must produce an intense emotional response such as "fear, hopelessness, and horror" to meet the criterion for a traumatic experience. The DSM-IV's greater emphasis on an individual's subjective emotional response to a stressful event is especially pertinent to UN and NGO personnel, since under the old definition, almost all peacekeepers and humanitarian staff would have been "traumatized" simply by virtue of their assignment to a war zone or disaster site. Under the DSM-IV definition, however, only those personnel who have had an intense emotional reaction to their stressful surroundings would be considered "traumatized."

The best research on PTSD among UN or NGO personnel concerns men and women who participated in peacekeeping operations. Estimates of PTSD vary greatly for UN peacekeepers. Some of this variation is

undoubtedly due to differences in the traumatic severity of the UN missions in question, while other variation may be due to methodological differences in the way in which PTSD was diagnosed. Here are some representative findings. Among both Norwegian and Dutch soldiers participating in the prolonged UNIFIL Lebanon operation, 5% had posttraumatic symptoms (Egge et al., 1996). Swedish soldiers deployed to Cyprus exhibited very little (0.5%) trauma-related psychiatric distress in contrast to 20% Canadian (Passey & Crocket, 1995) and 30% Danish (Madsen, 1995) personnel sent to Bosnia who exhibited PTSD symptoms. Among American men and women deployed to Somalia, 8% met criteria for PTSD (Litz, King, King, Orsillo, & Friedman, 1997; Litz et al., 1997).

In the only study on PTSD among NGO humanitarian personnel, 10% of returning staff met full diagnostic criteria for PTSD and about half (51.3%) reported moderate problems in at least one PTSD symptom cluster. Furthermore, higher levels of PTSD were generally associated with higher report of life-threat exposure (Eriksson et al., 2001). In addition, other anecdotal reports on traumatic stress and emotional distress among humanitarian personnel leave little doubt that such assignments carry a clear risk of long-term psychological problems, although it is impossible to speculate, in general, on the expected frequency of such adverse psychological outcomes (Smith et al., 1996). As with peacekeepers, the risk of acute or persistent psychological problems will depend, in part, on the severity, duration, and unique aspects of each distinct UN or NGO mission.

The risk of acute or persistent problems will also depend on the preventive and intervention strategies that are implemented in the field or immediately after repatriation, as will be discussed below.

Persistent Functional Impairment. Finally, the ultimate cost of such deleterious psychological consequences can be enormous. There are significant differences in long-term function and achievement between mentally healthy and well-adjusted individuals and those with PTSD, depression, alcoholism, and other psychological problems. Such deficits include lower levels of performance in educational attainment, marital stability, family function, vocational achievement, and societal engagement.

It appears that attention to prevention of and early intervention to reduce UN or NGO mission-related intense emotional responses can be expected to have a long-term payoff with regard to the mental health, quality of life, and personal achievements of former peacekeepers and civilian field personnel.

Consequences to UN or NGO Mission. The success of UN or NGO missions is clearly affected by the performance of its personnel.

Stress-related deficits in cognition, judgment, motivation, functional capacity, and morale can reduce the productivity and efficiency of UN or NGO personnel in the field. When psychologically affected individuals can no longer perform at an acceptable level or tolerate the emotional demands of their assignment, they must be removed from the theater of operation so that their personal deficits do not endanger or interfere with the performance of colleagues. UN or NGO personnel who must be reassigned or repatriated for such reasons reduce the effective workforce and must be replaced. It also appears that a significant number of UN or NGO personnel who must be removed for psychological reasons may never resume such duties in the future. Thus from an institutional perspective, the attrition of previously effective personnel is a lost investment, since such highly-trained individuals might have been expected to provide much more service to UN or NGO missions. Indeed, such mission-based psychological problems increase the costs of UN and NGO operations because of performance deficits in the field of operations as well as the attrition of trained personnel. As these consequences mount, it becomes increasingly difficult to achieve the goals and objectives of UN and NGO missions. In a worst-case scenario, reduced performance and effectiveness by military and civilian field personnel affect the credibility of the UN and NGO, respectively.

The Importance of Culture

As reiterated throughout this book, there is a wide range of ethnocultural expectations, explanations, and expressions of posttraumatic distress. Factors that must be considered include the cultural identity of the individual, culture-specific explanations for trauma-related emotional reactions, cultural factors related to the psychosocial environment in which peacekeeping or civilian missions must be carried out, cultural factors affecting the expectations and performance of professional responsibilities associated with the UN/NGO assignment, cultural factors that affect the recognition and acknowledgment of adverse psychological reactions, cultural factors affecting the willingness of distressed individuals to seek assistance, and cultural factors affecting the acceptability of different interventions for ameliorating such distress (Stamm & Friedman, 2000).

Given the cultural diversity among UN/NGO personnel, it is obvious that various conceptual models and intervention strategies will be better suited for some than for others. One useful way to characterize one dimension of cultural differences is the individualism-collectivism dichotomy (Keats, Munro, & Mann, 1989). People from more traditional cultures are often collectivists who perceive the self as part of a larger social unit, whereas individualists focus more on their own personal reactions

(Triandis, 1995). Therefore, the same event may be experienced and understood quite differently, since the collectivist may be most affected by its impact on the family, community, or tribe, whereas the individualist may be more distressed by his or her own personal symptoms and distress.

Such a cross-cultural perspective is not only crucial for understanding the psychological impact of posttraumatic stressors among different UN/NGO personnel, it is also essential for selecting the best and most culturally sensitive intervention strategy. Individualists are more likely to accept and respond to Western psychological approaches that focus on an individual's subjective symptoms. Collectivists may be more responsive to family interventions or ceremonies and rituals that involve the tribe or community at large. In this regard, it may be useful to think of UN/NGO military or civilian units as communities/tribes in which distressed personnel may benefit more from collective than from individual interventions. We will continue this discussion of culturally-sensitive approaches subsequently.

PREVENTION AND INTERVENTION

As illustrated in both vignettes, exposure to life-threatening danger and witnessing atrocities are inherent risks in many peacekeeping and civilian field humanitarian or social missions. Although it may be impossible to prevent such episodes, it is possible to minimize the short- and long-term emotional consequences of such experiences. Table 14.3 lists a number of

Table 14.3. Prevention and Intervention for UN Mission-Related Emotional Distress

Recruitment, Screening and Selection
Pre-deployment Training
• Education About Stress
• Preparation for Mission-Specific Stress Management
• Preparation for General Stress Management
• Preparation of Leaders
Self-help Interventions
• Defusing
Formal/Professional Interventions
• Debriefing/Other Acute Approaches
• Frontline Treatment
• Ceremonies and Rituals
Post-deployment Stabilization and Treatment
Organizational Response Plan

preventive strategies that have been utilized, mostly by military personnel and civilian disaster responders. Although systematic scientific evaluation of these approaches is at a relatively early stage, there is a growing experiential core of information to guide planning and to promote changes in current institutional policy and practice.

Recruitment, Screening, and Selection

In some future society, it may be possible to cite the known risk factors for maladaptive responding to extreme stress. Screening tools will have been devised to accurately identify those individuals most susceptible to stress at the point of entry into UN peacekeeping or civilian humanitarian or social institutions. In some cases, such individuals will not be permitted to participate because of irreversible vulnerabilities identified through this screening process. In other cases, individuals with reversible vulnerabilities will receive pre-deployment training that will fortify their capacity to cope with stress and make them suitable candidates for UN or NGO service.

At the present time, there is no information that might be used for such purposes. Although there are known vulnerabilities and risk factors for stress tolerance associated with a candidate's prior experiences and family history (Fairbank, Schlenger, Saigh, & Davidson, 1995; King, King, Foy, Keane, & Fairbank, 1999), such evidence has little practical utility because it cannot help predict which individuals will succumb to short-term or chronic stress under which conditions. This is due to the fact that the same event can have a different emotional impact upon different individuals. For this reason, in part, intervention targeted at the entire group seems most useful.

Predeployment Training

Predeployment training is the major opportunity for reducing mission-related stress reactions. Our discussion will focus on education about stress, preparation for mission-specific stress management, preparation for general stress management, and preparation of leaders.

Education about Stressors. The goal of this activity is to make sure that individuals learn about reactions to extreme stressors so that they will be prepared to recognize such responses in themselves if and when they occur. Such a proactive educational approach should help personnel understand that they are not losing their minds, that their constellation of symptoms has a specific name, that many people experience and

Table 14.4. Common Stress Reactions

Emotional	*Biological*
Shock	Fatigue
Anger	Insomnia
Disbelief	Hyperarousal
Terror	Somatic complaints
Guilt	Impaired immune response
Grief	Headaches
Irritability	Gastrointestinal problems
Helplessness	Decreased appetite
Despair	Decreased libido
Dissociation	Startle response
Loss of pleasure from regular activities	
Cognitive	*Psychosocial*
Impaired concentration	Alienation
Confusion	Social withdrawal
Distortion	Increased stress with relationships
Intrusive thoughts	Substance abuse
Decreased self-esteem	Vocational impairment
Decreased self-efficacy	
Self-blame	

Source: Young et al., 1998, p. 110

rapidly recover from such intense immediate emotional reactions, and that no stigma or shame should be associated with this kind of all-too-human response to an overwhelming experience. They need to understand that stress reactions typically include the emotional, biological, cognitive, and psychosocial symptoms shown in Table 14.4. Finally, they need to learn about potential sources of emotional and social support and where and when to seek counseling or other professional assistance.

Mission-Specific Stress Management. There should be a focus on stressors specifically related to the nature of the operation, such as combat exposure and the threat of death or capture, dealing with bodies and with wounded, exposure to mass human misery, prolonged separation from family and friends, sexual harassment or assault, issues related to collaborating with military or civilian field personnel from other nations and cultures, cultural isolation, or isolation from others due to working conditions and living arrangements.

General Stress Management. This component of stress management training focuses on stressors that are less directly related to the specific deployment under consideration. These include unit cohesion, morale,

confidence in leadership, training and equipment, and social support during and after the deployment.

Realistic training and rehearsals should be used to develop both skills and confidence to reduce operational stress. Simulation of dangers involved will enable personnel to become familiar with anticipated stressors, and to develop appropriate coping skills. The more thorough the training, particularly the more rehearsed the drills to be implemented during critical events, the more automatic appropriate reactions will become in real circumstances.

Military research has consistently demonstrated that levels of cohesion, leadership, and morale are significant predictors of combat stress casualties and that units high in these characteristics function more effectively (Belenky, Noy, & Solomon, 1987). These factors may provide a social support system that allows personnel to express themselves after intensely stressful experiences, possibly providing a cathartic mechanism in coping with stress. However, *cohesion should be built prior to deployment for it to be effective during and after stressful events.*

Preparation of Leaders. It is especially important that leaders be able to recognize traumatic stress symptoms in themselves and others, since they not only have responsibility for the welfare of others but must also make the critical decisions that determine mission success and the safety of those they lead. Because of this, leaders are more susceptible to stress and are more affected by additional stressors than are subordinates. Following a group crisis, the leader is the person who must deal with the emotional needs of subordinates and restore group function. This is why pre-deployment training must place so much emphasis on the preparation of leaders.

The UN Office of Human Resources Management has published a booklet entitled *Mission Readiness and Stress Management* that includes specific sections on mission readiness, stress management, critical incident stress, and the post-deployment homecoming (United Nations Office of Human Resources Management, 1995). It is a clear, concise, and very accessible example of the kind of written educational material recommended for both pre-deployment training and post-deployment readjustment.

Frontline Treatment

Frontline treatment was developed in a military context and is extensively utilized by many UN member nations during peacekeeping deployments. There is no reason why this approach couldn't also be utilized by civilian field personnel.

As developed originally in 1919 by the military psychiatrist T.W. Salmon (1919), frontline treatment has always emphasized the importance of administering psychological interventions as close to the front as possible. This process has been modified over time (Artiss, 1963; Neria & Solomon, 1999) but has retained the three major principles of Proximity, Immediacy, and Expectancy (PIE). *Proximity* involves providing the intervention as close to the active (combat) zone as possible. *Immediacy* refers to providing the intervention as soon as possible after an acute stress reaction. *Expectancy* involves providing education that the acute stress reaction is a normal response to an overwhelming event, and emphasizes that rapid recovery and resumption of normal duties is expected. The other expectation is that there will be no long-term adverse consequences from this transient emotional reaction.

In military psychology, the most widely used interventions in the field of operations are defusing and debriefing (see below). Evidence favoring the effectiveness of frontline treatment is stronger than that favoring either defusing or psychological debriefing (Neria & Solomon, 1999; Solomon & Benbenishty, 1986). The difference may be due to more individualized, flexible, and intensive attention to emotional reactions provided by frontline treatment in comparison with these other approaches. Further research is needed on all of these interventions to determine their applicability and efficacy under a variety of circumstances.

Defusing. Defusing is a process developed for disaster workers (Young, Ford, Ruzek, Friedman, & Gusman, 1998) that is applicable for stress management of UN personnel. It is designed as a brief (10- to 30-minute) conversational intervention that can take place informally during a meal or while standing in line for services, etc. "Defusings are designed to give survivors an opportunity to receive support, reassurance and information. In addition, defusing provides... an opportunity to assess and refer individuals who may benefit from more in depth (support)" (Young et al., 1998, p. 40). When an individual appears preoccupied with thoughts about a stressful event and indicates a willingness to discuss such thoughts, a typical defusing intervention progresses through four stages: a) *Fact finding* ("Tell me what happened"); b) *Inquiring about thoughts* ("What thoughts have you had about this event?" "What was the worst part?" "What are your thoughts now?"); c) *Inquiry about feelings* ("How did you feel during the event?" "How do you feel now?"); and d) *Support and reassurance*: assisting colleagues to cope with current distress by reminding them of normal reactions to stress (e.g., Table 4) to help mitigate self-criticism and worry about stress-related emotional reactions.

The main goals of defusing are to reduce the intensity of acute stress reactions and to fortify coping mechanisms that have worked before. When

provided by trained personnel, defusing can be a rapid and effective intervention. It is also a useful screening mechanism, since individuals who cannot benefit from a defusing or who become even more upset (as they attempt to recount the facts, thoughts, and feelings related to a stressful episode) may require a more intense intervention. As noted by Ørner (1995), the one-to-one counseling inherent in defusing "aims to ease the expression of feelings, promote understanding of (personal) reactions to critical incidents... (and) raise awareness of useful coping strategies" (p. 510).

There is evidence to suggest that early interventions provided by trained professional colleagues from the same unit, rather than by outside (mental health) professionals, are more effective and better accepted (Ørner et al., 2000). This would suggest that defusing may be a particularly useful intervention for peacekeepers or civilian field personnel. A recent report on 510 Swedish peacekeepers deployed to Bosnia shows the positive effect of defusing. One-third of these soldiers had experienced traumatic situations during service such as seeing wounded, maimed, or dead people, had witnessed violence between indigenous combatants, had been involved in a serious accident, or had been under attack. It was found that peer support followed by a defusing session led by the platoon commander (or similar leader) had a positive effect on the post-service mental health of the participants. Indeed, this approach had better results than peer support and defusing followed by a debriefing session led by a trained mental health professional who was not a member of the military unit (Larsson, Michel, & Lundin, 2000).

Debriefing. *Psychological debriefing* began in military psychiatry and was later applied to support civilian disaster workers (Mitchell, 1983; Raphael, 1986). It is widely used, but evidence is mixed concerning its effectiveness (Bisson, McFarlane, & Rose, 2000; Neria & Solomon, 1999). Debriefing is a group-oriented intervention provided at the site of and shortly after the traumatic event to facilitate emotional recovery from acute distress. Although there are a number of variations on this approach, there are nine general components in a typical debriefing usually conducted in groups of 10–20 (Dyregov, 1989; Bisson, McFarlane, & Rose, 2000; Neria & Solomon, 1999).

Introduction: Leaders introduce themselves, describe the process, and emphasize confidentiality.

Facts: Participants are each encouraged to report what they witnessed and what happened to them, when, who else was involved, and their relationship to anyone else experiencing the event at the same time.

Thoughts: Participants recount their thoughts during the event and at present.

General Reactions: Participants recount impressions perceived through the five senses: sight, hearing, touch, smell, and taste. This is because re-experiencing the traumatic events is often triggered by sense reactions.

Emotional Reactions: Participants are encouraged to share painful and previously unexpressed emotional reactions to the stressful event, such as fear, helplessness, horror, grief, rage, or guilt.

Support Systems and Coping During the Event: Participants are encouraged to share positive factors, if any, that enhanced coping and/or survival. This helps to underscore and crystallize an appreciation for one's own coping skills and other support systems during stressful incidents.

Normalization: While sharing such intense emotions and ventilating powerful feelings, group members learn that others have had similar emotions to their own.

Future Planning/Coping: The debriefer informs the group that it is quite natural to have certain reactions to such an overwhelming event: for instance, insomnia, nightmares, jumpiness, etc. Group members are encouraged to discuss their symptoms as well as continue to examine internal coping mechanisms and external social support for quick recovery and future resiliency.

Disengagement: The debriefer reviews (and may hand out written material on) the normal human response to overwhelming stress. The expectation is strongly reinforced that the current intense distress is a transient emotional reaction that will subside within weeks. Group members are cautioned to consider professional assistance if current symptoms are intolerable or if such symptoms persist beyond a month. They are also offered a list of available mental health professionals if they wish to seek further assistance.

There is little empirical evidence supporting the efficacy of psychological debriefing or showing that it prevents PTSD. Indeed, some research suggests that debriefing may even exacerbate posttraumatic distress under certain conditions (Bisson, McFarlane, & Rose, 2000; Neria & Solomon, 1999). On the other hand, these same studies suggest that 50–90% of debriefing recipients report their belief that this intervention facilitated their recovery from the acute emotional distress caused by the stressful event. In addition, Deahl and associates (2000) have reported reduced alcohol misuse among debriefed British peacekeepers deployed to Bosnia in comparison to nondebriefed soldiers; they suggest that future trials of debriefing should monitor a wider range of outcome measures than PTSD symptoms. Despite unanswered questions about the usefulness of debriefing and mounting evidence that it may be deleterious under certain conditions, it has become a routine procedure in many settings for both disaster

workers and military personnel. Further research is definitely needed to determine whether debriefing is effective and, if so, under what circumstances. We will return to these issues later.

Post-Exposure Interventions Reconsidered

Ørner and associates (Ørner, 1995; Ørner, King, Avery, Bretherton, Stolz, & Ormerod, 2000) have thoughtfully considered post-stress interventions for crisis workers from several original and heuristically rich perspectives. They have argued strongly against the routine and prescriptive use of debriefing following stressful episodes, emphasizing that most staff can be expected to cope successfully with mission-related stress and will probably require little or no special assistance to facilitate the transition to life at home. In addition, they suggest that early intervention should be provided by trained professional colleagues (as in defusing and frontline treatment) rather than by outside (mental health) professionals (who are often brought in to provide debriefing). Their results suggest that crisis workers prefer a flexible format for discussions about stressful events rather than the strict protocol utilized in debriefing. Furthermore, a majority of crisis workers report that nonverbal coping strategies, such as rest and relaxation, exercise, working hard, or using humor are more beneficial than talking about the traumatic event. In view of these observations, it is possible that the flexibility, individualization, non-verbal components, and administration by professional (military) colleagues may be important components that have contributed to the demonstrated effectiveness of frontline treatment.

Finally, Ørner (1995) states, "Ceremonies and rituals are integral to the culture of emergency services. They help define the relationship of each emergency service to its host community... to facilitate full reintegration of personal into their peer group" (p. 515). He cites as examples the healing and purification rituals of American Indian warriors seeking re-entry into their host tribes following warfare, and community (rather than Western individual) interventions "that take full account of the power and healing properties of group cohesion and belonging" (p. 516).

All of these factors are relevant to UN and NGO personnel. Indeed, there may be a number of approaches to post-stress interventions, from Western-style interventions involving group discussions to traditional non-verbal ceremonies and rituals. As we strive to develop a suitable repertoire of culturally sensitive interventions, we need to examine how best to harness the power of groups, family, and community to promote coping and recovery from the psychological impact of UN mission-related stress reactions.

In response "to the sharp increase in traumatic and prolonged periods of stress suffered by World Food Programme [WFP] staff and their families over the past few years," WFP initiated a program to "help reduce the harmful effects of stress and trauma experienced by WFP staff members" (Dufresne-Klaus, 2000). The objectives of this program are: a) to react quickly and effectively at the onset of emergencies; b) to prepare WFP staff members and managers prior to emergency startup and staff redeployment; and c) to prepare and strengthen WFP's future response to emergencies by training a cohort of pre-screened and pre-trained staff who are prepared for deployment to an emergency site within 24 or 48 hours' notice.

This program was launched January 10, 2000. Its goal is to train 80 Peer Support Volunteers within the first two years, and 18 staff had completed the two-week training workshop by April, 2000. Topics covered in the workshop included: communication skills, effective helping styles, being a Peer Support Volunteer in a multicultural environment, stress management techniques for self and others, the impact of trauma and posttraumatic stress, coping with loss and death, crisis management (how to handle emergencies), a (post-trauma) defusing model, intervention and referral, requirements and support for Peer Support Volunteers, advocacy issues, and "taking care of yourself" (Dufresne-Klaus, 2000).

We have detailed the WFP Peer Support Program to illustrate how one UN organization has acted proactively and decisively to systematically address mission-related stress that was clearly having a deleterious impact on the mental health of its staff and an adverse effect on its capacity to achieve its goals. Early feedback suggests to WFP that this program is working quite successfully (Dufresne-Klaus, personal communication, July 20, 2000).

As noted by Diana Russler (see UN Voice), "UNSECOORD has been given the mandate to develop a comprehensive United Nations policy" regarding stress management for UN personnel, especially those exposed to traumatic situations such as hostage-taking, evacuation, or the violent death of a staff member. UNSECOORD has designed a program by which "stress counseling and stress management training has been integrated ... (into its)... security management training program and offered to all staff working within the UN system." Such a program exemplifies the critical ingredients of adequate pre-deployment education and preparation along with the capacity to provide timely interventions for traumatized field personnel requiring appropriate counseling or other kinds of support. OCHA is also increasingly attending to the needs of their staff. They now offer training in recognizing and coping with traumatic stress, as well as post-deployment interventions (see Mark Bowden's UN Voice).

As UN humanitarian, social, and military missions become more numerous and more complex, we anticipate that stress management programs such as those currently implemented by WFP and UNSECOORD will continue to be established and to expand.

Post-Repatriation Stabilization and Treatment

Periodic post-repatriation follow-up should be a routine procedure to monitor the physical and psychological well-being of individuals who have participated in UN missions. In the vignette on the Kibeho massacre, it should be noted that every member of the Australian medical contingent received a follow-up letter 6 and 12 months after their return home.

Professional mental health resources should be available to the minority of UN and NGO personnel who, following deployment, remain troubled or continue to exhibit the types of stress-related problems listed in Table 14.2. Individuals who did not benefit from defusing, frontline treatment, or other acute interventions may benefit from counseling, psychotherapy, or medication. It is already noted that UN peacekeepers who must be repatriated before completion of their tour of duty are a very high-risk group for long-term psychiatric disorders, alcoholism, and suicide (Egge et al., 1996; Weisæth et al., 1996). They should receive a thorough psychiatric evaluation and follow-up after repatriation. There are many effective treatments for stress-related symptoms. It is beyond the scope of this chapter to review such approaches; more information can be found in Chapter 4 and elsewhere (Foa, Keane, & Friedman, 2000).

Because lasting psychosocial dysfunction can arise from stress-related psychopathology, considerable effort should be focused on helping returning individuals assume a useful social and occupational role. Involvement in regular social activities and the development of an interpersonal network with appropriate supports is important to reduce the risk of relapse. Special rehabilitation programs may therefore need to be provided.

Organizational Response Plan. In their manual on mental health services for civilian disaster workers, Young and colleagues (1996) have proposed a six-point organizational response plan to support personnel who will be exposed to stressful events in the line of duty:

Provide pre-deployment training, as described previously.

Provide outreach to staff since people who usually accept such hazardous duties are not likely to seek psychological support on their own.

Expect and prepare to address an increase in personnel problems such as alcoholism, substance abuse, marital conflict, family dysfunction, and financial concerns.

Train leaders and administrators to recognize the impact of stress-related problems on job performance with regard to on-the-job accidents, changes in productivity, and increased tension among personnel.

Provide formal recognition for contributions to the UN mission.

Offer a wide range of services, including written materials (e.g., newsletters, brochures, bulletin boards), educational presentations (on the impact of stress), information on available stress-management resources (e.g., self-help groups, counseling, mental health professionals), and training and opportunities for defusing, debriefing, and front-line treatment.

In April 1995, 300 members of an Australian medical contingent deployed to Rwanda to provide health care to the peacekeeping force (UNAMIR) were confronted by a massacre. The victorious Rwandan Patriotic Army (RPA) was convinced that many of the perpetrators of the previous year's genocide had taken refuge in the camp for internally displaced persons (IDPs) at Kibeho. For five consecutive days, thousands of Rwandan IDPs, packed into the small area of the camp, were surrounded by two RPA battalions. A sense of panic and desperation grew among the IDPs because RPA soldiers occasionally fired into the crowd, killing or wounding dozens by direct gunfire and dozens more from trampling as the terror-stricken crowd of IDPs stampeded towards safety. In addition, the RPA siege had prevented IDPs from receiving food at any time during these five days. On April 22, frantic and starving IDPs ran to find shelter from an approaching thunderstorm. RPA troops misinterpreted this sudden mass movement as an attack and began to fire into the crowd for an hour, killing 130 people. The Australian medical team worked furiously, treating those whom they thought had a chance for survival, until later that afternoon when an RPA platoon again opened fire into the crowd with heavy machine guns and rocket-propelled grenades. At this point, all medical work had to be suspended as UN staff sought protective cover in the bunkers. The massacre continued throughout the night. At first light the next day, Australian medical personnel counted 4,000 dead IDPs and an additional 650 who had been wounded.

Because his troops were so angry, frustrated, and horrified by what they had witnessed at Kibeho, the Australian Force Medical Officer (FMO) put in place a comprehensive stress management program that included debriefing by commanders, doctors, psychologists, and the chaplain. In addition, just before the return to Australia, army psychologists conducted group and individual debriefings, and everyone was followed by letter at the 6- and 12- month markers back home.

The FMO had been concerned about both acute and post-deployment emotional responses. Acutely, he feared that failure of UN personnel to control their intense anger and hatred against the RPA would provoke furious retaliation and more bloodshed. With regard to long-term consequences, a dozen Australian troops were quickly identified through these proactive measures who were having difficulty resolving the experiences to which they had been subjected. At least one of these individuals was referred for psychiatric support on immediate return to Australia.

In summary, more than half the Australian contingent served during that savage month at Kibeho. The contingent's planning, presence, military discipline, and compassion saved many hundreds of lives and almost certainly prevented a catastrophe during both the massacre and the final sad days of the siege. Prompt attention to the psychological distress of UN personnel with professional and timely stress debriefing facilitated acute and long-term recovery from the emotional impact of that episode (Warfe, 1998).

RESEARCH NEEDED

Promote research to understand *which factors protect* against the emotional impact of stress on peacekeepers and civilian field personnel and *which factors make individuals more vulnerable.*

Emphasize research that focuses on *coping and adaptive strategies* that minimize the impact of stressful situations on these groups.

Conduct research on the effectiveness of *preventive strategies (including education)* that could be applied in pre-deployment training.

Prioritize research on the *applicability and efficacy of specific acute on-site interventions* such as defusing, debriefing, ceremonies, rituals, or other procedures that may be applied to individuals or groups.

Emphasize research on the efficacy of follow-up interventions such as education, stabilization, ceremonies, rituals, counseling, alcohol/drug abuse rehabilitation, psychotherapy (especially cognitive-behavioral therapy), pharmacotherapy, marital/family therapy, and psychosocial rehabilitation. Such interventions should be tested in psychosocial (e.g., community, tribal, professional) units as well as in family/kinship and individual contexts.

RECOMMENDATIONS

- Carry out pre- and post-deployment monitoring and assessment in order to have an ongoing record of the psychological status and functional capacity of personnel who participate in UN peacekeeping or civilian humanitarian/social missions.
- Modify institutional structures and procedures in keeping with the Organization Response Plan outlined above in order to provide better pre-deployment preparation and post-deployment support for UN and NGO personnel.
- Ensure that needed education and training are included in all pre-deployment preparation.
- Provide psychological support during deployments in order to promote better coping and function.
- Promote post-repatriation stabilization and intervention (when necessary) for at-risk or prematurely repatriated personnel through psychosocial rehabilitation and/or mental health treatment.
- Follow-up returned personnel to monitor psychosocial well-being. Such an approach will make it possible to detect individuals with poor post-deployment psychological function in order to refer them for appropriate mental health services.

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